MEDICAL HISTORY FORM

Personal Details

Title: Mr/Mrs/Miss/Ms/Dr/Master

First Name: _____

Surname: _____

Also Known As: _____

Street Address: _____

Suburb:_____

State:_____ **Postcode:**_____

Medicare #: _____

Exp: ____/____

Date of Birth: ____/____/____

Email:_____

Occupation:_____

Phone(M):_____

Phone(H):_____

Phone:(W):_____

Emergency Contact Name:

_____

Emergency Contact Number:

_____

Private Health Fund: YES/NO

If YES, please list here:

_____

DVA: YES/NO

If YES: White/Gold (Please circle one)

DVA Number: _____

Doctor(GP):_____

Phone: _____

Do you have a regular Dentist?: YES/NO

If YES: Name: _____

Suburb: _____

How Did you Learn About Us? (Please Circle Below)

Friends/Family/Website/Google/ Veterans Affairs/ NIB/ HBF/ Medibank/ Whitecoat/ Facebook/ Instagram

Other Dental Practice: _____ Other (Please Specify): _____

Health History (Please tick if you have had, or have any of the following medical conditions)

☐ Artificial Joints

☐ High Blood Pressure

☐ Low Blood Pressure

☐ Asthma

☐ Bisphosphonate Therapy

☐ Bleeding Disorder

☐ Cancer

☐ Diabetes Type1/Type2(Please circle)

☐ Eating Disorder

☐ Epilepsy

☐ Fainting or Blackouts

☐ Cognitive Disability

☐ Bone Disorder

☐ Sinus Problems

☐ Reflux

☐ Hepatitis A/B/C

☐ HIV/AIDS

☐ Past Serious Disease

☐ Anxiety

☐ Depression

☐ PTSD

ALLERGIES:

☐ Codeine

☐ Iodine

☐ Latex

☐ Penicillin

☐ Sulphur

☐ Local Anaesthetic

☐ General Anaesthetic

☐ Heart Attack/Bypass/Pacemaker/Murmur/Valve Replacement **(Please circle)**

Please Turn The Page

MEDICAL HISTORY FORM

Smoking/Tobacco Use: YES/NO/PREVIOUSLY If yes, how many per day? _____

Ladies, is it possible you are pregnant? YES/NO/MAYBE If Yes/Maybe how far along? _____ Months

Are you currently taking any medications? **(Please List including duration of taking them)**

_____

_____

_____

_____

_____

Do you have any other medical conditions?

_____

_____

_____

_____

What is your reason for attending today? _____

When was your last dental visit? _____

When did you last have dental X-rays taken? _____

Are you still serving? YES/NO (If YES do you have a discharge date? If NO, please state years of service):

_____

Do you have a DVA Advocate? YES/NO

If yes, please write Name, Email Address and Mobile Number below:

Name: _____

Email Address: _____

Mobile Number: _____

All personal information collected at Above and Beyond Dental is handled in the strictest confidence. We will not release your records to anyone without your given, written consent. All information kept on this form is confidential and will remain as such. If we require a third party (specialist or treating practitioner) we will ask for your consent before divulging any information to them. By signing below, you agree to this policy.

Full Name: _____

Signature: _____ Date: ___/____/____